

PROGRAMME COORDINATING BOARD

Sixteenth meeting

Montego Bay, Jamaica, 14-15 December 2004

Provisional agenda item 2:

Women, Gender and AIDS

Executive Summary

At the 15th Meeting of the Programme Coordinating Board (PCB) in June 2004, the Board reviewed initial progress on the development of the Global Coalition on Women and AIDS. The Programme Coordinating Board decided that women, gender and AIDS would be one of the two substantive issues discussed at its thematic meeting in December 2004.

The AIDS epidemic is affecting women and girls in increasing numbers. Globally, just under half of all people living with HIV are female, compared to 46% ten years ago. Around the world, the epidemic's escalating impact on women is occurring in the context of profound gender, class and other inequalities. AIDS is affecting women most dramatically in places where heterosexual sex is the dominant mode of HIV transmission, as is the case in sub-Saharan Africa and the Caribbean. However, as the AIDS epidemics become more firmly established in other parts of the world, where the epidemics are driven by injecting drug use, unsafe sex among men and commercial sex, more women are becoming infected as one population bridges to the next. This paper provides an overview of the multiple vulnerabilities faced by women globally and which require more focused action in the fight against AIDS.

The document includes (1) an overview summary on why a stronger focus on women and girls is needed; (2) the latest development plan for the Global Coalition on Women and AIDS; and (3) backgrounders detailing seven key vulnerabilities of women with regard to HIV and AIDS.

Action required at this meeting

It is requested that the Programme Coordinating Board:

- i. call attention to the increasing impact of HIV and AIDS on women and girls and the need to include a stronger focus on these issues in global advocacy as well as in national responses to AIDS; and
- ii. support improved and intensified action related to women and AIDS, through further development of the Global Coalition on Women and AIDS, as well as integration of these issues into HIV and AIDS initiatives at all levels and through greater involvement of a wider range of partners.



Context

The AIDS epidemic is affecting women and girls in increasing numbers. Globally, just under half of all people living with HIV are female, compared with 46% ten years ago. In most regions, the proportion of women and girls living with HIV is growing, particularly in Eastern Europe, Asia and Latin America.

AIDS is affecting women most dramatically in sub-Saharan Africa and the Caribbean where heterosexual transmission is by far the predominant mode of transmission. Women and girls make up almost 57% of people living with HIV in sub-Saharan Africa and nearly half of the adults infected in the Caribbean. Adolescent girls aged 15-24 are particularly affected: in sub-Saharan Africa young women aged 15-24 years are 3 times more likely to be infected than young men of the same age and twice as likely in the Caribbean. When viewed by country, the figures are even more stark. The ratio of young women to young men aged 15-24 years living with HIV ranges from 20 women for every 10 men in South Africa to 45 women for every 10 men in Kenya and Mali. In addition to biological factors, the Secretary General's Task Force on Women, Girls and AIDS in Southern Africa concluded that one key factor in this phenomenon is intergenerational sex. Many girls have relationships with men 5 to 10 years older, who have had more chances of exposure to the virus.

In other regions, as the epidemic expands, women are being infected in greater proportions. Women now represent 36% of adults living with HIV in Latin America. In Eastern Europe and Central Asia the number of women living with HIV is increasing as more women acquire the virus from male partners who are injecting drug users or clients of sex workers. Women now comprise 34% of adults living with HIV in that region. In Russia, which has the biggest epidemic in this region, the proportion of women among people newly diagnosed with HIV is growing—up from one in four in 2001 to one in three just a year later.

As in Eastern Europe, parts of Asia are experiencing AIDS epidemics largely concentrated among injecting drug users, men who have sex with men, sex workers and clients of sex workers and their partners. As HIV spreads within and between particular population groups, it creates bridges into the general population, with women and girls increasingly affected. In East Asia, women comprise 22% of all adults living with HIV, and 28% of young people (aged 15 to 24 years) living with HIV. In South and South-East Asia, 30% of adults (up from 28% two years ago) and 40% of young people living with HIV are women and girls. Women now account for more than one-quarter of new HIV infections in India, according to estimates, and 90% of those who test positive at antenatal clinics say they are in single, long-term relationships.

Vulnerabilities

Women and girls face multiple inequities and layers of vulnerabilities – biological, cultural, social and economic. HIV and AIDS intensify these inequities. Adolescent girls are at particular risk:

- biologically through the immaturity of their reproductive tracts
- culturally through their role in the family as child-minders, care-givers and bread-winners of last resort
- socially through cross-generational and transactional sex
- economically through lack of access to education, training, assets and paid employment.

These vulnerabilities are intertwined: care-giving responsibilities limit access to school, lack of education further limits employment – but their combined effect is to make adolescent girls at high risk of HIV infection in an increasing number of countries

There is a range of problems that face women who survive adolescence. Women are often denied property and inheritance rights, have poor access to education, reproductive health care, economic and income generating opportunities, and often limited bargaining power within relationships and communities. Where violence against women is tolerated, women's ability to negotiate safe sex is further curtailed. In addition, social norms impose a dangerous ignorance on girls and young women, who are often expected to know little about sex and sexuality. That lack of knowledge magnifies their risk of HIV infection. In many places, HIV prevention efforts do not take into account the gender and other inequalities that shape people's behaviours and limit their choices. Until they do, these efforts are unlikely to succeed on the scale required to halt the spread of HIV.

The paradox of low risk and acute vulnerability

Many women do not become HIV infected through high-risk behaviour or factors within their control. This has significant implications for a response. Women need information and skills to protect and care for themselves and their families. To be effective, however, HIV prevention programmes targeting women and girls must look beyond personal risk behaviours to the *vulnerabilities* affecting women and girls. Messages advising women what they should or should not do are futile if they do not address the risks in the environments and communities in which these women live and which they cannot change on their own.

Information is not enough

Women and girls need more information. A recent UNICEF publication calls attention to the fact that in many countries high prevalence countries, more than 80 percent of young women aged 15-24 did not have sufficient information to protect themselves from HIV¹. It would be a mistake, however, to believe that the risks girls and women take stem only from lack of knowledge or understanding. In many countries where economic conditions are difficult, girls engage in transactional sex with older men in exchange for schools fees or for clothes, mobile phones, and status. Female sex workers often agree to sex without condoms, not because they lack information on the benefits of condoms or the risk of HIV, but because they get paid five times as much. Women need more than advice. They need resources, education, jobs – real options to live safely and productively in a world with AIDS.

¹ Young People and HIV/AIDS: Opportunities in Crisis, UNICEF, 2002.

Role of HIV Positive Women's Organizations

One key component of an effective response to AIDS is the full involvement of those women and men who are already living with HIV/AIDS. The lynchpin of any effective response to AIDS is the creation and development of strong civil society organizations which can advocate within their own communities and national contexts. As more women become infected with HIV, it is increasingly essential to strengthen their capacity to take on leadership roles, participate in advocacy initiatives, as well as to develop the management skills required for successful programme work. Women living with HIV are best placed to provide outreach and support to their peers and, by uniting, to have their voices, concerns, and needs heard by policy and decision makers.

Women's organizations need to be at the forefront of the AIDS movement, advocating for better access to education, health services, reproductive health services, treatment for sexually transmitted infections and HIV, and prevention of gender-based discrimination. Yet traditional women's organizations have been slow to make AIDS a top priority and have rarely linked up with HIV-positive women's groups or communities. This needs to change. A first step in this direction is to strengthen the capacity of networks of women living with HIV/AIDS to effectively participate in the regional, national and community responses to HIV/AIDS, and to develop the skills, reach, and influence to speak and organize on their own behalf.

The Role of Men and Boys

While much can be accomplished through women's own actions and leadership, men and boys have a vitally important and essential role to play. Men are the power brokers and gate keepers in most societies. They control most of the resources required to implement women's claims for justice, and without their commitment to equality and fairness, or in some cases, the rule of law, women must fight difficult and often untenable battles within their own communities. HIV transmission is about relationships. Without attention to the gender dynamics which drive interactions within these relationships, effective HIV prevention programmes will be stymied.

There is a growing recognition that HIV programmes should be based on an understanding of gender dynamics, on how decisions are made and implemented, and their interaction. Nowhere is the need clearer than in the provision of sexual and reproductive health services. Most family planning programmes focus exclusively on women, forcing women to take a disproportionate responsibility for safety, reproductive health and family size. The result is not only an extra burden on women, but a closed door to men.

A similar pattern is unfolding with regard to HIV prevention messages of *abstain, be faithful to one partner, and consistent condom use (ABCs)*. While women are often painted as victims, it is clear that first and foremost, women need to take responsibility for their own health and safety. That means getting informed about reproductive and sexual health and HIV prevention. And it means abstaining from sex, delaying sex, or practicing safe sex. But when it comes to negotiating safe sex, women, young or old, face many challenges. Women are often not in a position to abstain or insist on condom use, particularly within marriage. In fact, according to surveys, many women agree that a man has a right to beat his wife for

refusing sexⁱⁱ. In addition, a survey in South Africa revealed that 55% of sexually active young girls felt they could not say no to their partner and 33% were actually afraid to say no.ⁱⁱⁱ This phenomenon is further compounded in situations where girls are married before age 18.

There are intimate links between men's and women's vulnerabilities and risks – mediated in many cases by ideologies that suggest men should be knowledgeable, outward-going, physically strong, virile, and emotionally robust while women should be obedient, modest, nurturing, and ignorant in sexual matters. A gender-based approach would explicitly acknowledge that gender awareness and sensitivity should focus on the needs of both sexes.

Conclusion

It is this analysis that has led UNAIDS and its partners to call for greater advocacy and action with regard to the impact of HIV and AIDS on women and girls. The focus of this increased advocacy is specifically on women and AIDS, rather than gender and AIDS. This is deliberate. Nearly two-thirds of young people aged 15-24 years living with HIV are girls, and it is this alarming phenomenon which this effort seeks to highlight. Whilst acknowledging that gender inequalities fuel and sustain the epidemic, the global community must move beyond gender-based analysis into action. Programmes must work with men and women, with existing allies, as well as new partners in the women's movement to enhance the ability of girls and women to protect themselves from HIV and to live full lives even when infected or affected by AIDS. The profound changes required in gender dynamics and societal structures will take generations. Yet even a long journey begins with a single step. It is for this reason that UNAIDS, through the Global Coalition on Women and AIDS, calls on partners, governments and donors for increased attention to and action to ameliorate the increasing toll of HIV and AIDS on women and girls.

Attached to this document is a Development Plan for the Global Coalition on Women and AIDS, which gives an overview of the strategy and work areas of Coalition partners over the next year. Backgrounders 1-8 contain an overview of seven key vulnerabilities of women and girls with regard to HIV and AIDS. These are also the seven action areas of the Global Coalition on Women and AIDS.

Notes:

This paper has been abstracted from the 2004 UNAIDS Report on the Global AIDS Epidemic, the UNAIDS EPI Update 2004, and the paper "Women and AIDS: Working with Men" prepared by Peter Aggelton for UNAIDS, September 2004.

ⁱⁱ DHS Malawi (2000), Zimbabwe (1999), and Zambia (2000/2001).

ⁱⁱⁱ Kaiser Family Foundation/ (2000) South African National Youth Survey.



A UNAIDS Initiative

The Global Coalition on Women and AIDS

Development Plan

November 2004

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THE GLOBAL COALITION ON WOMEN AND AIDS

DEVELOPMENT PLAN

I Background and rationale

1. The Global Coalition on Women and AIDS is a movement of people, networks and organizations with **four key goals**: to raise the visibility of issues related to women, girls and AIDS; to catalyse action to address those issues; to facilitate collaboration at all levels; and, in so doing, to scale up action that will lead to concrete, measurable improvements in the lives of women and girls.
2. The Global Coalition focuses on **women and AIDS rather than gender and AIDS**. This is deliberate. Whilst acknowledging that gender inequalities fuel and sustain the epidemic, the profound changes required in male attitudes and behaviours, and societal structures, will probably take generations. In the meantime, nearly two thirds of young people aged 15 to 24 years living with HIV are adolescent girls. The Global Coalition seeks to include but move beyond gender-based analyses to action. It seeks to work with men and women, with existing allies, as well as new partners in the women's movement to give girls and women the chance to resist the virus and to live full lives even when infected or profoundly affected by AIDS.
3. The Global Coalition is a **voluntary coalition of partners** who are committed to making a difference and who recognize the power of *collective* rather than individual action. The Coalition has its own identity and brand image which helps bind partners together behind a set of common goals, values and targets.
4. The UNAIDS Secretariat serves as the hub of the Coalition—providing a framework, leadership and strategic direction for the manifold actors working under the umbrella of the Coalition.

II Strategy

5. The Global Coalition is founded on **six key principles**.
 - ***Women are not victims***, their vulnerability does not stem from inherent physical or psychological weaknesses. Women's resilience must be recognized and strengthened.
 - ***Adolescent girls are at particular risk***. They need to be provided with information, skills and resources that will allow them to avoid infection (and pregnancy) and live full and productive lives.
 - Many women who are infected with HIV—or at great risk of becoming infected—do not practise high-risk behaviours. We are caught in a ***paradox of low risk and high vulnerability***.
 - ***Change is possible***. The factors making women vulnerable to HIV are amenable to change given sufficient attention, commitment and resources.
 - ***Positive women are vital to change***. Women living with HIV and AIDS have a unique contribution to make in strengthening responses to the epidemic at all levels and in all sectors.

- **There is a role for men and boys.** Men and boys can serve as positive forces for change in improving the situation of women and girls.
6. The Global Coalition focuses on **seven action areas**. These are not the only areas in which action is necessary. Nonetheless, if positive change could be achieved in these areas, the situation of women and girls could be improved dramatically over the next five years. They include:
- **preventing HIV infection** among adolescent girls, focusing on improved reproductive health care;
 - reducing **violence** against women;
 - protecting the **property and inheritance rights** of women and girls;
 - ensuring equal access by women and girls to **care and treatment**;
 - supporting improved **community-based care** with a special focus on women and girls;
 - promoting access to **new prevention options** including the female condom and microbicides; and
 - supporting ongoing efforts towards **universal education for girls**.
7. Each action area is “convened” by one or two convening (or lead) partners. In most areas, the lead agencies include an international nongovernmental organization partnered with a UN system agency. Convening agencies are as follows:
- | | |
|---|------------------------------------|
| • preventing infection amongst adolescent girls | UNFPA/IPPF |
| • reducing violence against women | WHO/CWGL ⁴ |
| • protecting property and inheritance rights | ICRW ⁵ /FAO |
| • ensuring equal access to treatment and care | ICW ⁶ /WHO |
| • supporting community-based care | UNIFEM/YWCA/
HelpAge |
| • access to new prevention options | GCM ⁷ /IPM ⁸ |
| • universal education for girls | UNICEF/GCE ⁹ |
8. The Global Coalition is also encouraging work in two cross-cutting thematic areas: (i) development of bold and effective leadership for women, and (ii) the involvement of men and boys. High-level leaders—especially women—are being encouraged to speak out around women and AIDS with the support of groups such as the Council of Women World Leaders (CWWL). For example, the CWWL convened a meeting of women Ministers of Health during the World Health Assembly in May 2004 to encourage more proactive leadership around women and AIDS. The Coalition will provide support to the Young Women’s Christian Association (YWCA) and the World Association of Girl Guides and Girl Scouts (WAGGGS) to develop the leadership skills of young women and girls

? ⁴ Center for Women’s Global Leadership

? ⁵ International Center for Research on Women

? ⁶ International Community of Women Living with HIV/ AIDS

? ⁷ Global Campaign for Microbicides

? ⁸ International Partnership for Microbicides

? ⁹ Global Campaign for Education

around HIV. In addition, the Coalition will work with Parliamentarians and HIV-positive women's networks to develop their leadership skills. The Coalition also seeks to champion male allies and leaders to give voice and shape to calls for new models of masculinity.

III Subregional initiatives and national action

9. The Global Coalition supports subregional initiatives in a number of regions. The subregional initiatives focus on one or two action areas of particular relevance for the region. The goals of the subregional initiatives are similar to those of the Global Coalition:

- to raise the visibility of women and AIDS issues in the subregion;
- to strengthen the epidemiological and evidence base;
- to build robust partnerships at regional and country levels;
- to catalyse the development of national women and AIDS action plans, and to mobilize support for their implementation.

10. The most advanced of the subregional initiatives is the work catalysed by the Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa. The Report of the Secretary-General's Task Force, launched on 7 July, found that there was a high level of awareness of women's plight in the region, but few leaders knew what to do; that intergenerational sex was the main driver of the epidemic; and that civil society structures need support—especially those working with women. Follow-up action includes:

- subregional Advisory Group constituted—first met on 12 March 2004;
- National Action Plans on Women and HIV/AIDS developed in the nine focal countries;
- UNAIDS to help countries mobilize resources to implement the National Action Plans.

11. The **Mekong Initiative on Women and AIDS** was launched on 8 March 2004, with a focus on building partnerships with women's groups. The Lao People's Democratic Republic launched a National Coalition on 12 March, and there are plans to intensify work on women and AIDS in Cambodia, Viet Nam and parts of China in early 2005. In addition, women and AIDS issues are to figure more prominently in the Asia-Pacific Leadership Forum.

12. There will be a meeting on **HIV/AIDS and Gender in the Middle East** in Jordan in February 2005. A Steering Group has been formed comprising ICT/UNIFEM/UNFPA/IPPF/Ford Foundation to help shape the meeting. The meeting will focus on the promotion of women's human rights, capacity-building for women's organizations, advocacy and awareness-raising, and strategic information on gender risk and vulnerability.

13. The Global Coalition aims to catalyse action around women and AIDS in other subregions including East Africa, the Caribbean, Latin America and Eastern Europe before the end of 2005.

A more comprehensive approach will be taken at *national level*, where advocacy and programming is not neatly compartmentalized into seven action areas. The UN Theme Groups and UNAIDS country coordinators will work closely with national governments and civil society groups to encourage the development and implementation of strategies to address the gender dynamics of the epidemic.

IV Deliverables for the next 12 months

14. The XV International AIDS Conference in Bangkok proved a turning point with respect to women and AIDS. In his opening address to the Conference, Kofi Annan described the

toll that the pandemic has taken on women as a “terrifying pattern”. He went on to call for positive change that will give more power and confidence to women and girls, and a transformation of relations between women and men at all levels of society. Earlier this year, on International Women’s Day (8 March), the Secretary-General endorsed the Global Coalition on Women and AIDS as an initiative which could help bring about this “positive change”.

15. The Global Coalition will **combine advocacy and programme efforts by using advocacy to promote concrete, measurable action**. For example, successful messaging around women and girls has made it clear that girls’ education is a *necessity* not an option, and that prevention of mother-to-child transmission (PMTCT) programmes should include long-term treatment for women (the PMTCT-Plus concept). The Global Coalition will promote other messages that are more complicated, less understood but equally important. For example, that marriage is a risk factor for young women; that women should be prioritized in HIV treatment and care efforts worldwide; and that reducing violence against women and protecting their property and inheritance rights are effective HIV-prevention strategies. A comprehensive approach to prevention for women must reach beyond the traditional model of “ABC” (abstinence, be faithful, use condoms) and address the real challenges facing women and girls.
16. The advocacy and communications efforts of the Global Coalition will reinforce this year’s World AIDS Campaign, which focuses on women and girls. By the end of 2004, advocacy efforts will ensure that the Global Coalition is a clearly-branded umbrella movement with its own identity; raise awareness—both among the general public and policy-makers—on the complexities surrounding women and AIDS; and provide the issue with a media platform from which to enhance its visibility. Furthermore, a Leadership or Advocacy Council of high-profile campaigners will be formed to promote the Coalition and its seven action areas. The advocates or “champions of the Coalition” will highlight the links between women’s vulnerability to AIDS and concrete actions that can turn the epidemic around.
17. For each of the seven action areas, the Global Coalition aims, by mid-2005, to have: (i) built a broad partnership network; (ii) improved the evidence base; and (iii) developed a discrete set of advocacy messages to support amplified programming and funding for women and AIDS. Progress to date for each action area is detailed in Annex 1.
18. At regional level, the Global Coalition will have dedicated focal points in the UNAIDS Intercountry Teams to catalyse and support subregional initiatives and national women and AIDS efforts. By the middle of 2005, at least one substantive effort—such as a meeting or the launch of a subregional initiative—will have been organized and supported in five subregions
19. At country level, there will be robust women and AIDS action in at least 12 target countries by mid-2005, which the Global Coalition and subregional initiatives can champion and use as models elsewhere. The Global Coalition will help fund-raising within countries to enable partners to turn National Women and AIDS Plans into action, including working with bilateral partners and funding bodies such as the Global Fund to Fight AIDS, TB and Malaria.
20. The UNAIDS Secretariat will raise funds to support the work of the convening agencies and partners, and to provide catalytic funding for the subregional initiatives and for initial national planning efforts in the target countries.

ANNEX 1

Global Coalition on Women and AIDS Summary of Progress

Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>Preventing HIV infection in adolescent girls UNFPA/IPPF/Young Positives</p>	<ol style="list-style-type: none"> 1) Background Paper summarizing key findings from literature review of preventing HIV infection among girls and young women. 2) Article entitled “Women and HIV/AIDS: it’s not as simple as ABC” has been accepted for publication in Sexual Health Exchange October 2004. 3) Confronting the crisis: joint UNAIDS/UNIFEM/UNFPA report on women and AIDS released Bangkok 2004. Publication has been widely disseminated, including Asia-Pacific Conference on Women and AIDS and will be available at the UNAIDS PCB meeting. 4) London School of Hygiene and Tropical Medicine and Liverpool School of Tropical Medicine, under the auspices of the Interagency Task Team on Young People, held in Talloire, France, a global consultation on evidence for policy and programming on HIV and AIDS and young people. 	<p>Partners meeting 14–16 June 2004, Kenya, to discuss experiences related to preventing HIV infection in girls and young women. 39 partners represented.</p>	<ul style="list-style-type: none"> • Draft advocacy messages have been developed by UNFPA, IPPF, Young Positives and are currently being refined. • Population Action International has agreed to work on advocacy plan and brochure, Terms of Reference have been drafted and shared. Draft expected end 2004. • UNAIDS, AGI, UNFPA, and IPPF issued press release in November on 'New analysis calls for increased integration of reproductive health and HIV prevention services'

Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>Violence against women:</p> <p>a) Reducing violence against women WHO and Sixteen Days of Activism</p>	<p>Symposium: “Dangerous Intersections: Current and future research perspectives on HIV and Violence against women”, 15–17 June, Baltimore, USA.</p> <ol style="list-style-type: none"> 1) File of preparatory materials. 2) CD-ROM of presentations from meeting. 3) Publication of proceedings (pending). 4) Special issue of WHO Bulletin to publicize unpublished material (exploring): <p>Multi-country study in 10 countries—analysis includes looking at linkages between domestic violence and HIV. Launch March 2005.</p> <p>Article in Lancet May 2004: Dunkel et al. showing that women with violent male partners are at increased risk of HIV infection.</p> <p>Working on gender indicators, including violence against women, to link with Millennium Development Goals and United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators.</p>	<p>Partnership meeting 14 June, Baltimore, involving Center for Women’s Global Leadership (CWGL), CHANGE, Rutgers University, Global Campaign for Microbicides, OHCHR, UNIFEM, Amnesty International, ICRW, Soul City, Kaiser Foundation, Human Rights Watch, ICW and ICASO.</p> <p>Formation of a working group to develop operational plan for Global Action Campaign.</p>	<p>Violence against women lunchtime panel during 60th session of UN Commission on Human Rights in Geneva. HIV and AIDS will be the focus of the 2005 report.</p> <p>Two information briefs to be released by World AIDS Day: one on violence in conflict situations and a second on domestic and sexual violence. A third on violence against female sex workers will be released in 2005.</p> <p>Opportunities:</p> <ol style="list-style-type: none"> 1) 16 Days of Activism against Gender-based Violence for 2004 and 2005 will focus on links between violence against women, women’s health and HIV/AIDS. 2) 10-year review of Beijing Platform for Action, March 2005. 3) UNGASS Declaration review, June 2005. 4) Millennium Summit/Millennium Development Goals review, September 2005. 5) World AIDS Campaign focus on violence against women as a priority theme—one of the WAC posters will be dedicated to this theme and will bear the logos of UNAIDS, WAC and GCWA.

Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>b) Reducing HIV infection among women during situations of conflict WHO</p>	<p>Assessment tool being field tested. Tool will collect data on links between violence against women during conflict and HIV transmission in Angola, Zimbabwe, and Democratic Republic of Congo.</p>	<p>Meeting between UNAIDS, WHO, UNFPA and RIASCO to discuss development of tool to assess the quality and responsiveness of health services to women's health in emergency settings.</p>	<p>To be developed. Emergencies and AIDS website will be posted in six weeks or so and any available materials posted on this site. Also available—a fact sheet on women in emergency settings in relation to HIV and AIDS.</p>
<p>Property and inheritance rights ICRW and FAO</p>	<p>Report entitled “To have and to hold” focuses on women's property rights/HIV and AIDS.</p> <p>Mridula Swamy: a survey of 30 organizations in Nepal, India, Bangladesh and Sri Lanka, working on women's property and inheritance rights. A paper will be finalized and submitted for publication in early fall.</p> <p>FAO to release paper on the impact of AIDS in rural areas. Data is not gender disaggregated as not available.</p>	<p>Meeting in December 2004: leadership council to be selected to advise ICRW on development of advocacy and action strategy.</p> <p>Two national conferences on property and inheritance rights will be taking place in Africa—Zimbabwe and Uganda—focusing on national and regional issues.</p>	<p>Advocacy strategy to be finalized at council meeting in December 2004.</p> <p>Major media event in Washington DC for World AIDS Day sponsored by ICRW and MAC AIDS Foundation. One event targeting the diplomatic community in Washington and a second Technical Consultation on Women and AIDS for nongovernmental organizations and activists.</p>

Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>Equal access to care and treatment ICW/WHO</p>	<p>ICW policy paper and series of vision papers:</p> <ul style="list-style-type: none">a) gender equity and poverty;b) access to care and treatment;c) meaningful involvement of positive women in decision-making;d) young women and girls; ande) human rights. <p>“Visibility and voices” publication pulling together participatory research on women living with HIV and AIDS from different countries.</p> <p>WHO about to issue Guidance on Ethics and Equitable Access to HIV and AIDS treatment and care.</p> <p>Launch of UNHCR-commissioned document on human rights abuses of HIV-positive women in Asia-Pacific region.</p>	<p>ICW with Gender AIDS Forum and Youth Against AIDS network, young women’s dialogue, Durban, 26–30 April, to develop a young women’s advocacy agenda. One day was specifically on the “3 by 5” initiative.</p> <p>Partners meeting planned for 2005.</p> <p>WHO and UNAIDS to issue joint statement on gender issues related to equal access to treatment.</p>	<p>To be developed.</p> <p>August 2004: Global Advocacy officer recruited.</p>

Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>Community-based care UNIFEM/YWCA/HelpAge International</p> <p>Title proposed: Women's Unpaid Care Work within the family and the community</p>	<p>“Expanding the care continuum for HIV: Bringing carers into focus” paper produced by ICRW and Horizons, initiated by UNIFEM and ILO.</p> <p>UNIFEM and the Tropical Institute of Community Health and Development (TICH) in Africa, 2004: “Assessment of the Gender Dimensions of HIV/AIDS Care Perceptions, Policies, and Practices in East and Horn of Africa” (currently in draft, to be available shortly).</p> <p>UNIFEM publication “Why Should we care about Unpaid Care Work?” by Debbie Budlender, that provides methodologies and examples of advocacy work, including reference to HIV/AIDS.</p> <p>Fact Sheet: The Care Economy (to be included in the upcoming IATT on Gender and AIDS Resource Pack and used as a backgrounder for Advocacy work).</p> <p>Scan of nongovernmental organizations and projects involved in work relating to home-based care and to the care economy and women's roles within the community in relation to HIV and AIDS.</p> <p>Two-page background note prepared for launch of GCWA February 2004.</p> <p>Southern Africa under the subregional initiative: a desk review of women's involvement in home-based care for HIV and AIDS currently in process.</p>	<p>Partners meeting to be held in Nairobi, 8-10 November 2004.</p>	<p>To be developed.</p> <p>(Some potential messages already identified, to be discussed at partners meeting.)</p>

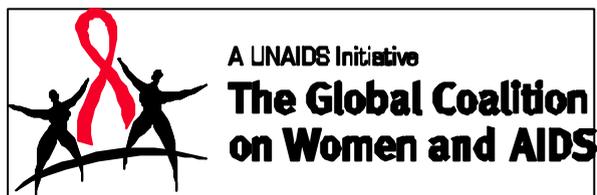
Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>Promoting access to prevention options for women, including microbicides/female condoms IPM/GCM</p>	<p>Revised estimates on public health impact of introducing a 60% efficacious microbicide in collaboration with London School of Hygiene and Tropical Medicine; submitted to American Journal of Public Health.</p> <p>Publication of three case studies of the impact of introducing microbicides in three different settings: Karnataka, India; Cotonou, Benin and Hillbrow, South Africa.</p> <p>Publication of “Mobilizing Community Involvement in Microbicide Trials: A Dialogue in Southern Africa”.</p> <p>Two-page background note on the female condom now on the GCM website.</p> <p>IPM CEO spoke at “Acting on Rights: Women and HIV/AIDS”, a satellite session during the International AIDS Conference. IPM prepared a policy paper on gender and microbicides for this event. IPM CEO also updated participants of the International AIDS Conference on the state of microbicide research.</p>	<p>February 2004– Consultation with Indian women’s movement on Women’s HIV Prevention needs, jointly sponsored by GCM + Joint Action Front for Women—a coalition of Indian nongovernmental organizations.</p> <p>Day-long, pre-conference skills - building training for advocates at Microbicides 2004 conference.</p> <p>A partnership meeting to be organized by the GCM is planned for November.</p>	<p>Condoms are highly effective, but consistent condom use is difficult to achieve in primary partnerships.</p> <p>With sufficient resources and political will, a microbicide could be developed by the end of the decade.</p>

Theme/Convenors	Improving the evidence base	Partnership Meeting	Advocacy messages and events
<p>Supporting efforts towards Universal Girls' Education UNICEF and GCE</p>	<p>The Center for Universal Education of the U.S. Council on Foreign Relations report: "What Works in Girls' Education", by Barbara Hertz and Gene Stirling.</p> <p>The Global Campaign for Education: "Learning to Survive".</p> <p>Forthcoming report: UNICEF, Special Report on girls' education and HIV/AIDS to be launched January 2005.</p>	<p>The Global Advisory Committee for the UN Girls' Education Initiative (UNGEI) met for the first time in New York, 22-23 April 2004. This will serve as the principle partner forum.</p> <p>Next meeting will be held in Brazil November 2004, along with the EFA High Level Group meeting. Links with UNGEI to be made.</p> <p>Planning Meeting scheduled for 19 January in Johannesburg to propose agenda on Girl's Education for GCWA</p>	<p>Advocacy around abolition of school fees.</p> <p>Three key messages:</p> <ul style="list-style-type: none"> • Get and keep girls in school. • Ensure schools provide quality life-skills-based education which empowers students. • Promote safe environments around schools.

Evidence Base across all action areas:

Nov 23 – UNAIDS to release the Epidemiological Update 2004 which includes a chapter on latest data on women and AIDS.

Dec 1 – FAO to release new data on the impact of HIV and AIDS on rural populations.



Backgrounder 1

CARE, WOMEN AND AIDS

All over the world women are expected to take the lead in domestic work and in providing care to family members.

HIV and AIDS have significantly increased the care burden for many women. Poverty and poor public services have also combined with AIDS to turn the care burden for women into a crisis with far-reaching social, health and economic consequences.

The term 'care economy' is sometimes used to describe the many tasks carried out mostly by women and girls at home such as cooking, cleaning, fetching water and many other activities associated with caring for the young, sick and elderly in the household. The value of the time, energy and resources required to perform this unpaid work is hardly recognized and accounted for, despite its critical contribution to the overall economy and society in general.

Women and girls pay an opportunity cost when undertaking unpaid care work for HIV- and AIDS-related illnesses since their ability to participate in income generation, education, and skills-building diminish. AIDS intensifies the feminization of poverty, particularly in hard-hit countries, and disempowers women. Entire families are also affected as vulnerability increases when women's time caring for the sick is taken away from other productive tasks within the household.

A study in the village of Kagabiro in Tanzania, demonstrated that when a household included someone with AIDS, 29% of household labour was spent on AIDS-related matters. In two thirds of the cases two women were devoted to nursing duties and on average the total labour lost to households was 43%.

Research has established that up to 90% of care provided to cope with illness is provided in the home. The vast majority of women and girls who shoulder the HIV and AIDS care burden do so with very little material or moral support. They receive no training, no special materials such as gloves, medication, and food, and no means to pay for children's school-fees.

The combined physical and emotional burden of caring for sick household members, including orphans and others who have been affected by the disease, of trying to ensure an adequate food supply, medicines and school fees and of replacing lost income inevitably often forces women to neglect their own health and well-being.

As working-age people increasingly become sick and die of AIDS-related illnesses, the loss of household income forces older women back into the workforce. At a late age, they often become the sole carers and providers for their adult children and orphaned grandchildren. Young girls and adolescents are forced to sacrifice their education to provide care within the home and face reduced prospects for decent work opportunities. For example in Swaziland, school enrolment is reported to have fallen by 36% due to AIDS, with girls most affected.

The growing impact of the epidemic has shown that HIV and AIDS home care needs to extend its support beyond the person infected by HIV and include his or her family and household members. Home-care programmes have shifted from an exclusive focus on medical and nursing care to

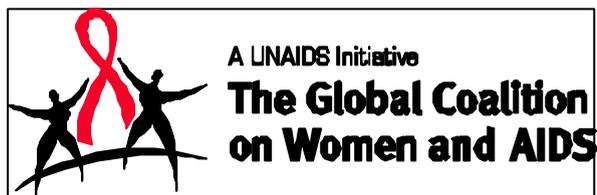
include counselling, food assistance, welfare support, school-fees for orphans and income generation for widows. Some programmes have successfully involved men and demonstrated that working with men helps change traditional attitudes and cultural beliefs about gender roles, vital to diverting the course of the epidemic.

However, home-care programmes are often critically short of kits containing gloves, soap, disinfectants and other basic necessities. Mostly they depend on female community volunteers who are barely able to cope. Government involvement is limited and would diminish further without donor-support. Clearly there is also an urgent need to expand support to HIV- and AIDS-affected households beyond the health sector if issues of social and economic security are to be addressed effectively.

Much of the care work performed by women and girls is remains unpaid and therefore unaccounted for and undervalued in economic terms. National AIDS Plans hardly take into account the devastating effects of HIV and AIDS on women in the household. A first step towards improving this situation would be to establish women's care burden as an issue. The case must be made that women's care work implies costs to women, households, communities and national economies, and that something can and must be done to reduce women's excessive care burden in the context of HIV and AIDS.

A number of things can be done to raise awareness about the impact of HIV and AIDS on the disproportionate care burden shouldered by women and girls and to encourage action to tackle the problem. They include:

- highlighting the magnitude and implications of women's unpaid care work in terms of social and economic costs and benefits, both to themselves, their communities and the larger society;
- encouraging governments, national and international policy makers, communities and households to recognize the urgent need to scale up and broaden social protection and support for caregivers at community and household level; and
- advocating for changes in the gender division of domestic labour at household level and achieving gender equity in care responsibilities.



Backgrounder 2

AIDS AND GIRLS' EDUCATION

Girls are less likely than boys to attend school for many of the following reasons.

- Parents are more likely to spend limited funds on educating a boy.
- Many families do not understand the benefits of educating girls, whose role is often seen as being prepared for marriage, family and domestic responsibilities.
- Girls in many communities are already disadvantaged in terms of social status, lack of free time due to high burden of domestic tasks, access to resources, and even lack of food.
- The burden of care for ill parents and younger siblings often falls on girls, which jeopardizes their ability to attend school; this is most pronounced in AIDS-affected societies.

An estimated 104 million primary-school aged children were not enrolled in school at the turn of the millennium with girls making up 57% of the total. Girls are also more likely than boys to fail to complete secondary education because of early marriage, pregnancy and care duties at home.

In high prevalence countries, girls' enrolment in school has decreased in the past decade. Girls are the first to be pulled out of school to care for sick relatives or to look after younger siblings. AIDS is threatening recent positive gains in basic education and disproportionately affecting girls' primary school enrolments.

Girls and young women are often expected to know little about sex and sexuality, but this lack of knowledge puts them at risk of HIV infection. Surveys have shown that fewer girls than boys aged 15 to 19 have basic knowledge about how to protect themselves from HIV and many misconceptions exist and remain uncorrected in communities with limited access to accurate information. Often, these myths can be damaging to girls and women, for example, "having sex with a virgin can cure HIV".

Going to school is protective. Education is one of the key defences against the spread of HIV and the impact of AIDS and the evidence for this is growing. While ensuring girls are in school is important to reducing overall vulnerability, it is insufficient without specific measures to provide information, skills and links with school-community services.

Girls who stay longer in school and receive education on life skills and sexuality benefit from delayed sexual debut, increased HIV-prevention knowledge and condom-use rates among those already sexually active, and improved understanding of HIV testing. There are three key lines of action in the education response to HIV and AIDS and its effects on girls and these can be supported by strategic activity.

1. Get girls into school and ensure a safe and effective environment which can keep them at school and learning.

- Abolish school fees. Evidence shows that even in the face of extreme poverty, removing school fees reduces costs of schooling to parents and communities, making education

attainable for large numbers of children who could not previously afford school. This is especially the case in ensuring access to secondary schooling for girls.

- Use incentives such as bursaries and food. Targeting vulnerable households or communities with benefits of money or food have been successful ways to increase attendance amongst girls. School subsidies provide multiple benefits and are easier to monitor than other sorts of direct subsidies. Many countries have successfully used school subsidies to increase access to education for girls.
- Improving girls' access to school is central, but schools must be safe and provide an effective learning environment, which in turn will encourage staying at school, and make the experience worthwhile for girls as well as boys.
- Schools must work to reduce discrimination girls and young women face at school, by enforcing appropriate policies and practices.

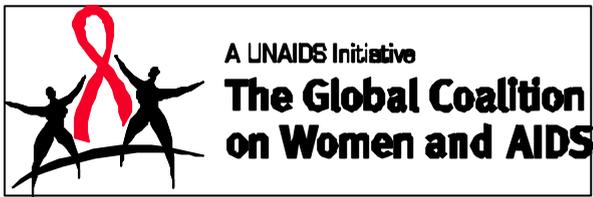
2. Provide life-skills based education with a focus on gender issues and preventing HIV, as part of the overall quality education that all children and young people deserve.

- Schools provide an ideal opportunity to ensure girls' and boys' access to good quality [skills-based HIV and AIDS education](#), not only through traditional teacher-based methods, but also through school-community connections with civil society organizations.
- Well-implemented school-based HIV-prevention programmes have been shown to reduce key HIV risks, particularly when they go beyond the provision of information. They also help young people develop knowledge, attitudes and life skills needed to protect themselves against HIV.
- In addition to the direct benefits to individual knowledge, and behaviours, quality life skills-based programmes can also help to:
 - foster equal partnerships and participation between boys and girls, young men and women;
 - make sure that HIV- and AIDS-related messages do not reinforce gender stereotypes or other biases related to HIV-status, race, religion, and tackle entrenched cultural practices such as early marriage;
 - promote equity among boys and girls, young men and young women in care-giving for relatives living with HIV and AIDS; and
 - strengthen home-school-community partnerships to better coordinate education with other complementary strategies such as supportive policies and legal frameworks, access to condoms and to prevention and treatment services for sexually transmitted diseases.

3. Protect girls from violence, exploitation, and discrimination in and around schools

The experience of girls in schools is not always good; schools can be scary environments, especially for young women, due to the prevalence of gender-based violence. Gender-based violence occurs when someone is abused because he or she is female or male. Harassment is one form of this. Schools have a special role in combating gender-based violence, both in helping learners to understand the attitudes and structures that promote it and how their behaviour contributes; and in helping the healing process.

Schools need to establish security measures and codes of behaviour which go beyond the immediate school environment to reduce harassment and violence, gender discrimination and girls' exploitation. Such measures need to consider travel to and from school, as well as natural school-community connections and traditional ways of ensuring the safety of girls and boys in and around schools.



Backgrounder 3

MICROBICIDES, WOMEN AND AIDS

Women are twice more likely than men to contract HIV from a single act of unprotected sex, but they remain dependent on male cooperation to protect themselves from infection.

Women need methods to protect themselves from HIV that they can control. One of the most promising prevention options on the horizon is microbicides. Like today's spermicides, microbicides would be used vaginally or rectally by people wishing to protect themselves and their partners from HIV and other sexually transmitted diseases.

Formulated as a gel, film, sponge, lubricant or time-release suppository, a successful microbicide could provide primary protection to women and couples who cannot or do not use condoms. Once developed, microbicides and vaccines would serve as complementary prevention technologies, with microbicides putting the power of prevention directly into the hands of women.

With sufficient political will and investment, a first-generation microbicide could be ready for distribution in as little as five to seven years. However, investment in microbicide research and development must expand dramatically and quickly if the promise of microbicides is to be realized. The incentive structure of the private market is currently failing to drive investment in microbicides—despite the fact that estimates suggest a potential US\$ 1.8 billion market for a successful microbicide by 2020. In 2002, the Rockefeller Foundation estimated that roughly US\$ 775 million would need to be invested in testing existing products in the pipeline to have a high likelihood of guaranteeing a successful product by the end of the decade. Worldwide available microbicide research and development funding at the end of 2002 totalled US\$ 343 million. A gap well in excess of US\$ 400 million exists between what is needed and what is currently available. Substantially increased resources are required to ensure that the most promising candidate microbicides can proceed through Phase III testing without delay and to lay the groundwork for the efficient distribution of this critically needed technology.

The microbicide field is different from others addressing neglected public-health technologies because a number of product developers already exist. However, virtually all the entities are small biotechnology companies, not-for-profit organizations, and academic institutions with limited funding and capacity. Of the 40 potential microbicides under development today, none has a major pharmaceutical company sponsor.

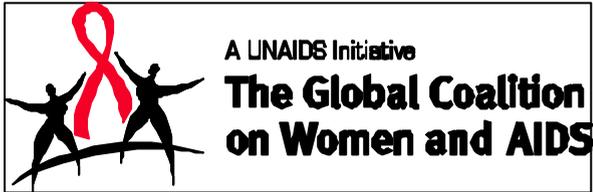
Products under development vary widely. Some are likely to be contraceptive as well as microbicidal, while others are designed as non-contraceptive tools solely for disease prevention. According to preliminary data several appear to be broad-spectrum products capable of reducing the risk of HIV and other sexually transmitted diseases.

To date, 11 microbicides have advanced into human safety trials and four of these are scheduled to enter large-scale Phase II/III trials in 2004 to measure their effectiveness. Since Phase III trials take at least two years for data collection and another two years for data analysis and registration, microbicide advocates cite five to seven years as the soonest a new product could become available. Even this timeline may not be met, however, without more funding to keep research moving.

Using mathematical modelling, researchers at the London School for Hygiene and Tropical Medicine showed that even a 60%-effective microbicide could have substantial impact on the epidemic if introduced into the world's 73 lowest-income countries. If such a product were used by only 20% of those women already in contact with health services, 2.5 million new infections could be averted among women, men and children in three years.

In May, 2003, the Global HIV Prevention Working Group called for US\$ 3.8 billion in additional annual spending by 2005 for existing prevention programmes. Specifically, the Working Group (a 40-member, international panel of leading public health experts, clinicians, biomedical and behavioural researchers, and people affected by HIV and AIDS) recommended additional public-sector spending of US\$ 1 billion for microbicides. Realistically, this is the level of investment needed to hasten the advent of first-generation microbicides. These first products, the Rockefeller Foundation study predicted, will create enough of a market to attract private investment. Market forces will then drive the development and refinement of second- and third-generation microbicides, which are expected to have efficacy rates as high as 80% to 90%.

UNAIDS is working with a number of microbicide-specific organizations and networks (including the International Partnership for Microbicides and the Global Campaign for Microbicides) to highlight the critical need for female-controlled prevention options and to prepare nongovernmental organizations and advocates to be active partners in this endeavour.



Backgrounder 4

PREVENTING HIV INFECTION IN GIRLS AND YOUNG WOMEN

Compelling evidence demonstrates an urgent need for prevention strategies that reach girls and women. Globally there are now 17 million women and 18.7 million men between the ages of 15 and 49 living with HIV and AIDS. Since 1985, the percentage of women among adults living with HIV and AIDS has risen from 35% to 48%. Of particular concern are the dramatic increases in HIV infection among young women, who now make up over 60% of 15 to 24 year-olds living with HIV and AIDS. Globally, young women are 1.6 times more likely to be living with HIV and AIDS than young men. In some countries, adolescent girls face infection rates that are five to six times higher than those of boys the same age.

The United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa identified three key factors that contribute to the greater vulnerability of the subregion's women and girls to HIV infection:

- the culture of silence surrounding sexuality;
- exploitative transactional and intergenerational sex; and
- violence within relationships with boys and men.

The Task Force further emphasized that all three factors must be understood and addressed in the context of the poverty and inequalities that define the daily lives of both women and men in the region.

Even though girls and women are highly vulnerable to HIV infection, they know less than males about HIV and AIDS and how HIV is transmitted. Data from UNICEF surveys conducted between 1998 and 2003 on condom use among 15 to 20 year-old youth revealed that globally more than 80% of young women did not have 'sufficient' knowledge about HIV and AIDS. Many had no idea how HIV is transmitted and little or no information on protection methods. In South-East Asia only 13% of young women were able to correctly identify two prevention methods (using condoms and limiting sex to one faithful, uninfected partner) and three common misconceptions about HIV and AIDS. In addition, many young women did not know that a healthy-looking person can be infected with HIV.

The situation is exacerbated as in many societies both the discussion about sex education and sexual matters is discouraged. As a result, millions of people, especially girls and women, remain ignorant about HIV and AIDS with potentially deadly consequences. Breaking the silence is essential. We need to communicate that talking about sexuality and health is important; coercion, force and sexual violence is unacceptable and represents a violation of women's rights; protecting oneself from HIV is a necessity and the means to do so are available.

The power to use knowledge

For many girls and young women, knowledge is not enough. The rising rates of HIV infection among girls and young women require approaches to prevention that address their specific needs and realities and that are linked with other reinforcing elements such as access to treatment and care, economic empowerment and the implementation of rights. Effective prevention includes education, health services, media campaigns, behaviour change, life-skills building, including self-esteem and job training. Understanding gender roles and the way they impact in sexual and reproductive life, and how they affect HIV prevention is critical.

The low social status of girls and women, unequal access to resources, vulnerability to coerced-sex and domestic violence, economic dependence on men and little ability to negotiate methods of protection translates into common prevention approaches being insufficient. For young women and girls, it's not as simple as 'ABC' (Abstain, be Faithful, and use Condoms). For example, abstinence is meaningless to girls and young women who are coerced or forced into sexual activity. Faithfulness offers little protection to wives whose husbands have several partners or who were infected before they were married. Condoms require the cooperation of men, who may refuse to use them. Furthermore, married couples frequently do not use condoms either because they want to have children or because condoms would indicate a lack of trust. In many countries, including several with high rates of HIV infection, girls are married in their teens as a poverty-reduction strategy. However, recent studies in Africa indicate that young married women are at higher risk of HIV infection than their unmarried counterparts.

The ABC approach will present viable options for girls and young women only if it is implemented as part of a multifaceted package of interventions that take into consideration their specific problems. Interventions should aim to empower girls and young women through assertiveness and self-esteem building and interpersonal communication and leadership skills development. They must be accompanied by changes in laws and community support as well to transform social expectations that would allow them to live independent lives both socially and economically.

Encouraging dialogue between young men and young women will also help ensure that young men are sensitized about respect and safer sexual behaviour, and that young women are able to articulate what they want as well as what makes them comfortable. Children should be socialized from an early age to respect the human rights of girls and women and to reject gender discrimination and violence.

Prevention

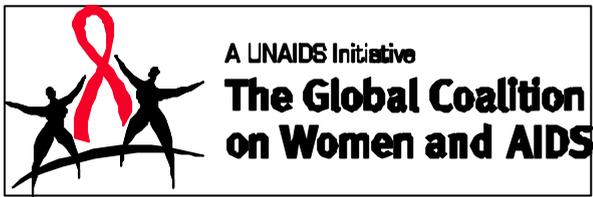
Globally, only one fifth of those who need prevention services have access to them, and in parts of the world where HIV-infection rates are threatening to explode, many people, especially in rural areas, have little or no access to health care in general, which is an important source for prevention. This is especially true for young people, who have few entry points to the existing health-care system.

Studies about voluntary counselling and testing show that it can contribute to a decrease in unprotected sexual relations, a reduction in multiple partners, an increase in condom use and more people choosing abstinence. Along with male condoms, female controlled methods of prevention (e.g., the female condom which is available and microbicides which are under study) have to be made available on a much larger scale. These methods have the potential to provide young women and girls with greater control over sexual relations.

Charting the way forward

Prevention, including behaviour change communication activities, information channelled through public services or use of male and female condoms is an important part of reversing the epidemic. While treatment, particularly universal access to antiretrovirals, will make a huge difference to the lives of people living with HIV, prevention methods that promote gender equality and women's human rights can stop the epidemic in its tracks, and steadily reverse the rate of infection. Above all, young women and girls need alternatives, including economic opportunities. They stand a better chance of living healthy and satisfying lives in societies that value their productive as well as reproductive roles. Strong leadership at all levels to address gender inequality as central driver of the AIDS epidemic as well as empowering girls and young positive women are necessary actions for stopping the epidemic, and for achieving the Millennium Development Goals by 2015.

The full text of the report "Women and HIV/AIDS: Confronting the Crisis" published jointly by UNFPA, UNAIDS and UNIFEM addresses many of the prevention issues facing girls and young women and can be accessed by following this link: [United Nations Population Fund - UNFPA](#).



Backgrounder 5

AIDS AND FEMALE PROPERTY AND INHERITANCE RIGHTS

Around the world, issues of access to, ownership of, and control over land, housing, and other property are enshrined in many national constitutions and international human rights documents. Despite the proliferation of property and inheritance laws and rights, many women and girls—particularly in the developing world—are denied their rights.

Where women lack title to land or housing, they suffer restricted economic options, reduced personal security, poverty, violence, and homelessness, contributing to both their and their children's impoverishment. Poverty can also encourage risky livelihood measures, such as enduring an abusive relationship or engaging in unsafe sex in exchange for money, housing, food or education.

In many countries, women's rights to land and property are attained primarily through marriage. If the marriage ends, women's rights to land or home may end as well. An Oxfam report on the situation in Mozambique notes the country has a dual legal system, common in many countries, with a 'customary' legal system operating in parallel to a Western-style legal system. In countries where laws do exist, there is often widespread illiteracy and people have no real access to formal court systems, lawyers and other legal resources. Often they do not even know that such a system exists.

While property and inheritance rights are important for women generally, they take on dramatically increased importance in the context of HIV and AIDS. The effects of property dispossession are now being documented and need further attention:

- an FAO study in Namibia reported 44% of widows lost cattle, 28% small livestock, and 41% lost farm equipment in disputes with in-laws after the death of a husband;
- in a Uganda pilot study of 29 widows living with HIV, 90% had property wrangles with in-laws and 88% of those in rural areas were unable to meet their household needs.

There is growing evidence to suggest that upholding female property and inheritance rights helps mitigate negative economic consequences of AIDS experienced by women and their households. Evidence also suggests that it can help prevent the spread of HIV by promoting women's economic security and empowerment, thereby reducing their vulnerability to domestic violence, unsafe sex, and other AIDS-related risk factors.

Conversely, discriminatory inheritance practices have negative consequences for AIDS-affected households. Widows suffer partial or total loss of assets, including their land and homes, to relatives of the deceased spouse leaving such households destitute and more vulnerable to further consequences of HIV and AIDS.

Across regions, the status of women's property and inheritance rights, gendered patterns of ownership and control, and rates of HIV infection vary greatly. Among developing regions, Latin America has the most favourable legal traditions and relatively egalitarian gender inheritance norms, though some land reform and post-war resettlement initiatives have neglected gender concerns.

In South Asia, notable inequalities in property matters remain across religious and ethnic communities despite extensive organizing and mobilization on women's rights. In many parts of the Middle East and North Africa, property and inheritance matters are largely governed by *Sharia* law, though other legal codes and international human rights standards often pose a challenge to those addressing property issues there. In sub-Saharan Africa multiple legal regimes incorporating old colonial laws, more recent constitutional law, and ongoing 'customary' law (and in some places *Sharia* law) overlap in a complicated legal pattern that often fails to recognize or uphold women's property rights, a particularly distressing situation given the region's high rates of poverty and HIV and AIDS.

Guaranteeing women's property and inheritance rights in the context of HIV and AIDS requires both global- and country-level actions.

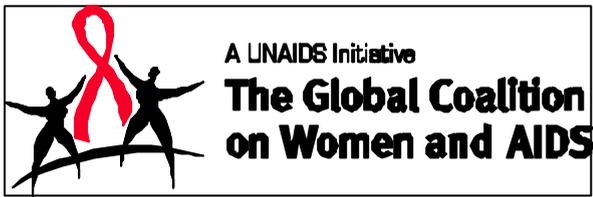
At the global level, the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) has focused on equality in property as one of its important directives and a number of United Nations initiatives have also focused on the issue and passed a number of resolutions.

At the country level, three types of legal change are necessary: amending laws, increasing legal literacy, and recording women's share of property—which is especially important in South Asia and sub-Saharan Africa. While many countries have made efforts to review and reform relevant law—constitutional, marital, property, family and equal opportunity—translating these laws from theory into practice at community level remains a challenge.

Several countries have established paralegal services to help women pursue and defend their property and inheritance rights. Related to this are community- and national-level activities involving the training of traditional leaders, community and women's groups and professionals including lawyers, judges, registrars and police. Although such activities are considered generally successful, there are concerns about ensuring sustainability and uniform standards.

Successful action will focus on five key areas:

- documenting women's land and housing rights and tenure security in high HIV prevalence areas;
- raising public education and awareness, especially among national policy makers and donors;
- reforming legislation, including 'customary' law and practice;
- identifying strategic litigation opportunities, especially improving legal skills, establishing legal precedents through test cases, improving the court system, and ensuring women's access to legal structures and processes; and
- identifying and supporting experimentation within communities to change economic and institutional arrangements including initiatives that seek to support the collective ownership or lease rights to land and establishing land trusts for AIDS orphans.



Backgrounder 6

AIDS TREATMENT—A FOCUS ON “3 by 5”

On World AIDS Day 2003, WHO and UNAIDS released a detailed and concrete plan to provide antiretroviral treatment to three million people living with AIDS in developing countries by the end of 2005. This is a vital step towards the ultimate goal of providing universal access to AIDS treatment to all those who require it.

The problem is urgent: 30 million people have died of AIDS in two decades and 40 million more people are currently infected. In poor countries, six million people with HIV and AIDS need antiretroviral treatment immediately. Today only about 400 000 people receive antiretroviral treatment—less than 8% of those in need. Without accelerated prevention and treatment the AIDS epidemic will continue destroying communities, health care systems and economies, placing a shadow upon the future of entire countries.

The “3 by 5” initiative, as it is known, aims to support countries to rapidly achieve the target of three million people on treatment. Key efforts within “3 by 5” include revised, simplified and standardized guidelines on the application of antiretroviral therapy in resource-constrained settings; support for the purchasing, financing and supplying of HIV drugs and diagnostics through an AIDS medicines and diagnostics service; and, standardized monitoring and evaluation tools as well as training packages for professional and lay health workers on antiretroviral treatment. It also boosts initiatives to build the capacity of communities and community-based organizations, including people living with HIV and AIDS, to participate fully in the delivery of antiretroviral treatment services.

Women and children make up a large proportion of people living with HIV and AIDS in need of care, treatment and support. Worldwide, almost half of adults living with HIV are women. However, in the most heavily stricken region, Africa, women are at least 1.2 times more likely to be infected with HIV than men. Young women and girls are even more susceptible to HIV than men and boys, with studies showing they can be 2.5 times more likely to be HIV-infected as their male counterparts.

High numbers of pregnant women visiting antenatal care clinics are HIV-positive. In many southern African countries, more than one in five pregnant women is infected with HIV. The overwhelming majority of children contract the infection from their mothers, during pregnancy, delivery, or through breastfeeding. The 700 000 new infections among children in 2003 (14% of all new infections) represent an unacceptable and almost entirely preventable component of the epidemic. In too many places, voluntary counselling and testing services are still absent, and a mere 1% of pregnant women in heavily-affected countries have access to services aimed at preventing mother-to-child transmission of HIV.

Through the “3 by 5” initiative, WHO and its partners will develop principles and mechanisms to promote and provide equitable access of antiretroviral treatment and care services to women, girls and children including marginalized groups of people living with HIV and AIDS.

In response to the overwhelming situation of HIV infection among women and children, WHO is taking a comprehensive approach to build HIV care, treatment and support into existing prevention programmes, using services for the prevention of mother-to-child transmission as the entry point to deliver antiretroviral treatment, other care, and support to HIV-infected women, their children and families.

At this stage, it is difficult to predict what proportion of those receiving treatment under the "3 by 5" initiative will be women. However, it is likely that women will be at least half of those on treatment by 2005 and may in fact substantially outnumber men. The reasoning behind this is that first, in African countries most affected by AIDS, the burden of disease falls fairly equally but usually with a bias towards women. Second, some of the key entry points anticipated for treatment are relevant for women only. While tuberculosis, sexually transmitted infection, primary health care clinics, and voluntary counselling and testing centres are all likely to be used both by men and women, antenatal care and services to prevent mother-to-child transmission, will only be used by women and may in fact be the source of many candidates eligible for treatment.

VIOLENCE AGAINST WOMEN AND AIDS

Violence against women is a major human rights and public health problem worldwide. It increases female vulnerability to HIV.

One of the most common forms of violence is that perpetuated against women by intimate partners or 'domestic violence'. Of women globally, 10% to 50% report physical abuse by an intimate partner at least once in their lives, and this is often accompanied by sexual violence. Domestic violence is one of the leading causes of female injuries in almost every country in the world according to Human Rights Watch. It is associated also with a wide range of general, reproductive and mental health problems.

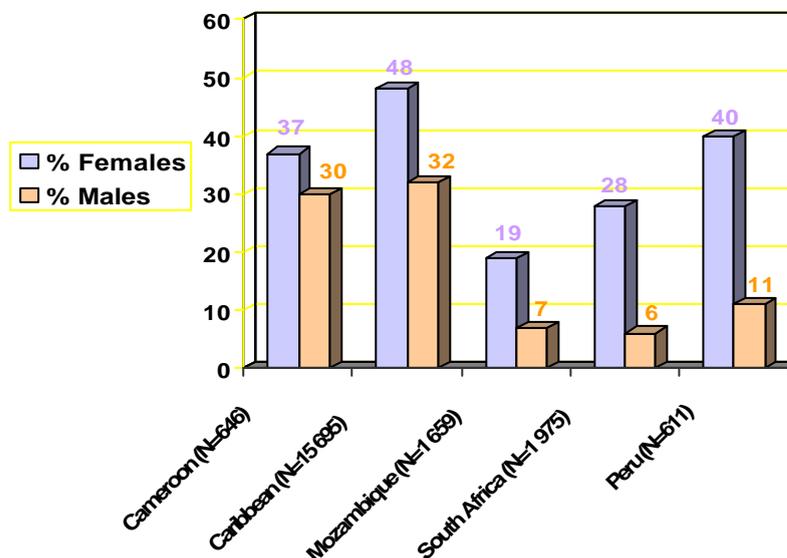
Violence against women is common in nearly all societies. It is supported by, and in turn serves to reinforce, discrimination against and subordination of women. As well as domestic violence, recent conflicts have seen an increase in the use of rape and sexual violence as tools of war; in addition trafficking, the sex trade, and other forms of commercial violence also increase female vulnerability to HIV.

For many women worldwide the threat of violence that permeates their everyday lives exacerbates their vulnerability to HIV. Fear of violence prevents women from accessing HIV and AIDS information, being tested, disclosing their HIV status, accessing services for the prevention of HIV transmission to infants, and receiving treatment and counselling, even when they know they have been infected. This is particularly true where HIV-related stigma remains high.

The high incidence of non-consensual sex, women's inability to negotiate safer sex, and in many cases fear of abandonment or eviction from homes and communities, present extreme challenges—particularly for women who lack economic means.

In South Africa, national youth surveys show that 33% of young women report they are afraid of saying no to sex and 55% have sex when they do not want to because their partner insists.

% Adolescents reporting forced sexual initiation (age range 10-25 years)



More alarming, between 20% to 48% of adolescent girls aged 10 to 25 have reported that their first sexual encounter was forced. Boys also report experiencing forced sex, but in many countries this is usually less common than among girls.

It is not just young women coerced into sex outside of marriage who are at risk. A young married woman engaging in monogamous heterosexual sex with her husband can also be at risk. In these circumstances traditional messages of prevention are of little relevance as condoms are less likely to be used inside marriage.

For example, a study in Zambia found that only 11% of women interviewed believed that a woman had the right to ask her husband to use a condom—even if he had proven himself to be unfaithful and was HIV-positive.

In Kisumu, Zimbabwe, research has revealed that the majority of HIV-positive women were infected by their husbands. Furthermore, married women who suspect their husbands are HIV-positive do not always have many options. According to one woman interviewed as part of the study, “We see our husbands with wives of men who have died of AIDS. What can we do? If we say no to sex, they’ll say pack and go. If we do, where do we go to?” The study found that one of three HIV-risk factors was being married or having been married.

Women face additional obstacles due to the pervasiveness of discriminatory legal frameworks which fail to guarantee equal rights or equal protection before the law. In many cases, inequitable divorce and property laws make it difficult for women to leave abusive relationships, and in countries where laws against gender-violence exist, insufficient resources, coupled with discriminatory practices by police and courts and lack of institutional support, leave women without access to adequate protection.

The past 20 years have seen a growing recognition of violence against women in the public policy agenda. Successful advocacy campaigns have led to increased awareness and a stronger policy and legal environment.

Despite this, violence against women continues to be widespread and often socially sanctioned or tolerated. There are, however, a small number of promising initiatives for prevention and community mobilization against violence. These programmes need to be studied, supported, and expanded.

A comprehensive response to tackle violence against women and HIV and AIDS must include:

- mobilizing leadership at global, national, and community levels to generate action to ensure that normative change occurs to make violence against women unacceptable;
- expanding the evidence base highlighting the prevalence of violence against women, including the economic, social and health costs, and its links to HIV and AIDS—this includes support to and expansion of on-going initiatives such as the WHO multi-country study on violence against women;
- building the knowledge base on the relationship between violence against women and HIV and AIDS, and disseminating this information to researchers and practitioners in both fields; and
- promoting national- and community-level action that improves the education and legal standing of women and builds on successful efforts and encourages innovation and partnership among groups working on both issues.

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